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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Texas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

1. Subject to the qualifications, limitations, and exclusions in the amount, duration and scope of benefits and elsewhere as provided in the State Plan, payment to eligible providers of laboratory and x-ray services except the technical component of those services described in number 3 below, radiation therapy, physical therapists' services, physician services, podiatry services, chiropractic services, optometric services, dentists' services, and psychologists' services are reimbursed based on the Texas Medicaid Reimbursement Methodology (TMRM). (Refer to item 6 of this attachment for reimbursement of EPSDT dental services.)

   a. Except as otherwise specified, the TMRM for covered services provided by physicians and certain other practitioners employs a prospective payment system which is based upon the Single State Agency's determination of adequacy of access to health care services as described in this section, or the actual resources required by an economically efficient provider to provide each individual service.

      (1) There shall be no geographical or specialty reimbursement differential for individual services.

      (2) The fees for individual services will be reviewed at least every two years and will be based upon either (i) historical payments, with adjustments, to ensure adequate access to appropriate health care services; or (ii) actual resources required by an economically efficient provider to provide each individual service.

   b. Definitions. The following words and terms, when used in this section shall have the following meanings, unless the context clearly indicates otherwise.

      (1) Access-Based Reimbursement Fees (ABRF) - Fees for individual services based upon historical payments adjusted, where the Single State Agency deems necessary, to account for deficiencies relating to the adequacy of access to health care services as defined in subparagraph (2) of this paragraph.

      (2) Adequacy of Access - Measures of adequacy of access to health care services include, but are not limited to, the following determinations:

(i) Adequate participation in the Medicaid program by physicians and other practitioners, and/or

(ii) The ability of the eligible Medicaid population to receive adequate health care services in an appropriate setting.

(3) Resource-Based Reimbursement Fees (RBRF) - Fees for individual services based upon the Single State Agency's determination of the resources required by an economically efficient provider to provide individual services. An RBRF is defined mathematically by the following formula:

$$RBRF_1 = (RVU_{w\text{-}1} + RVU_{o\text{-}1} + RVU_{m\text{-}1}) * CF$$

where,

$RBRF_1$ = Resource-Based Reimbursement Fee for Service 1

$RVU_{w\text{-}1}$ = Relative Value Unit for Work for Service 1

$RVU_{o\text{-}1}$ = Relative Value Unit for Overhead for Service 1

$RVU_{m\text{-}1}$ = Relative Value Unit for Malpractice for Service 1

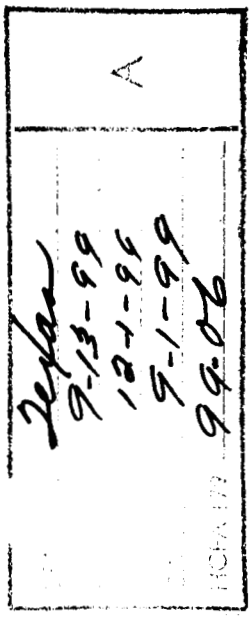
CF = Conversion Factor

(4) Conversion Factor - The dollar amount by which the sum of the three cost component RVUs is multiplied in order to obtain a reimbursement fee for each individual service. The initial value of the conversion factor is $26.873. The conversion factor will be updated based on the adjustments described in subparagraph (5) of this paragraph at the beginning of each state fiscal year biennium. For the 2000-2001 biennium (September 1, 1999, through August 31, 2001) the conversion factor will be updated by 1.5 percent. The Single State Agency may, at its discretion, develop and apply multiple conversion factors for various classes of service such as obstetrics, pediatrics, general surgeries, and/or primary care services.

(5) Conversion Factor Adjustments - The biennium adjustment of the conversion factor is composed of the following two components:

(i) Inflation Adjustment - To account for general inflation, the conversion factor is adjusted by one-half of the forecasted rate of change of the implicit price deflator - personal consumption expenditures (IPD-PCE). To inflate the conversion factor for the prospective period, the Single State Agency uses the lowest feasible IPD-PCE forecast consistent with the forecasts of nationally recognized sources available to the Single State A gency at the time of preparation of the conversion factor(s).

(ii) Access-Based Adjustment - Adjustments to the conversion factor may also be made to ensure adequacy of access as defined in subparagraph (2) of this paragraph.

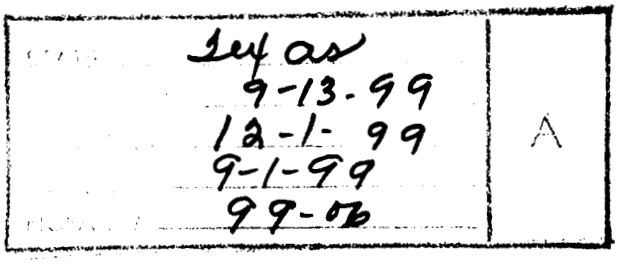


4. The amount payable for outpatient hospital services provided by approved Title XIX hospitals is determined under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248, except as may be otherwise specified by the Single State Agency including the application of the following reduction percentages. Medicaid reimbursement for outpatient hospital services shall be at 77.6% of allowable cost. For the 2000-2001 biennium, reimbursement for outpatient hospital services shall be at 80.3% of allowable cost. Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to ambulatory surgical centers (ASCs) for similar services, the hospital's actual charge, the hospital's customary charge, or the allowable cost determined by the Single State Agency or its designee.

5. Refer to Item 5 on page 2 b.

6. Refer to Item 6 on page 2 a.

7. Payment for family planning services are made in accordance with the provisions contained in items 1, 3, 35 and 41 depending on the service provided and the provider type. For other agencies which are physician directed and are approved to provide family planning services under this state plan, the upper limits for payment will be not in excess of a fee schedule, as approved by the Single State Agency, for each of the professional services authorized as benefits.



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(6) Relative Value Units (RVUs) - The relative value assigned to each of the three individual components which comprise the cost of providing individual Medicaid services. The three cost components of each reimbursement fee are intended to reflect the work, overhead, and professional liability expense required to provide each individual service. The RVUs that are employed in the TMRM must, except as otherwise specified, be based upon the RVUs of the individual services as specified in the Medicare Fee Schedule. The Single State Agency will review any changes to or revisions of the various Medicare RVUs and, if applicable, adopt the changes as part of the TMRM.

c. Calculating the payment amounts. The fee schedule that results from the TMRM must be composed of two separate components:

(1) the access-based fees, and

(2) the resource-based fees which must be composed of RVUs for the work, overhead, and malpractice components. The sum of these components must then be multiplied by the conversion factor to produce a reimbursement fee for each individual service.

2. Ambulance services are reimbursed in accordance with a reasonable charge methodology. The Single State Agency or its designee defines and determines reasonable charges and payments based on reasonable charges as follows:

a. A reasonable charge is a charge for a specific service which is the lowest of:

(1) the provider's customary charge for that service,

(2) the prevailing charges made for similar services in the geographic locality, or

(3) the actual charge of the eligible provider.

b. The Single State Agency or its designee uses a statistical base for making reasonable charge determinations. The statistical base is comprised of individual charges gathered from available sources, including Medicare (Title XVIII) and Medicaid (Title XIX).

c. Determination of reasonable charges, as set forth in this section and established by the Texas Board of Human Services, is made in accordance with applicable federal requirements. Payments for services provided must not exceed the Medicare allowable charges.

3. The technical component of clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients is reimbursed on the basis of the Medicare-established fee schedule.

STATE Texas
DATE REC'D 3-12-92
DATE APPV'D 9-2-92
DATE EFF 4-1-92
HCFA 179 92-06
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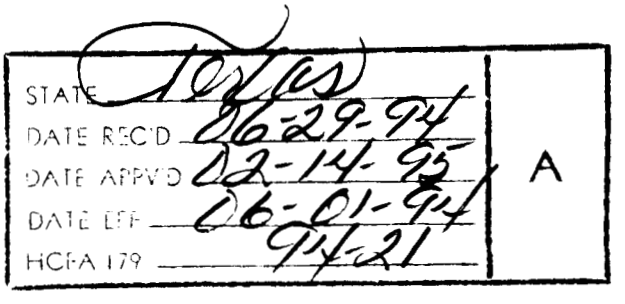
4. The amount payable for outpatient hospital services provided by approved Title XIX hospitals is determined under similar methods and procedures used in Title XVIII of the Social Security Act, as amended, effective October 1, 1982, by Public Law 97-248, except as may be otherwise specified by the State Agency including the application of the following reduction percentages. During FY94 Medicaid will reimburse at 94.6 percent of cost and during FY95 at 89.4 percent of cost. During FY96 Medicaid will reimburse at 83.65 percent of cost and thereafter at 77.6 percent of cost. Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to Ambulatory Surgical Centers (ASCs) for similar services, the hospital's actual charge, the hospital's customary charge, or the allowable cost determined by the State Agency or its designee.

5. Refer to Item 5 on page 2 b.

6. Refer to Item 6 on page 2 a.

7. Payment for Family Planning services are made in accordance with the provisions contained in items 1, 3, 35 and 41 depending on the service provided and the provider type. For other agencies which are physician directed and are approved to provide family planning services under this state plan, the upper limits for payment will be not in excess of a fee schedule, as approved by the State Agency, for each of the professional services authorized as benefits.

6. Payment for basic Early and Periodic Screening, Diagnosis and Treatment services is made through contractual arrangement with the single state agency or its designee, except the single state agency or its designee will pay for certain services provided by the Texas Department of Health (TDH) based on actual costs. These services include EPSDT medical screening laboratory services; tuberculin test materials (PPD/Mantoux Antigen and syringe); and immunization for vaccine-preventable diseases for individuals ages 19 and 20 years of age who are Medicaid eligible, but outside the scope of the Vaccine for Children Program. Payment for screening services will be based on the lesser of billed charges or a fee schedule established by the single state agency or its designee. The fee schedule amounts paid to health departments for performing EPSDT screening services will not exceed the health department's actual cost, in accordance with OMB Circular A-87. The fee schedule amount is identified in Item 30 of Attachment 4.19-B. Participating providers are reimbursed an administrative fee per dose of vaccine for the provision of immunizations based on the lesser of billed charges or a fee schedule determined by the single state agency or its designee. Participating dentists are paid by the single state agency or its designee their usual and customary rate or on a fee schedule determined by the single state agency or its designee, whichever is less. Reimbursement for more definitive diagnostic and treatment services is made though other contractual arrangements between the single state agency or its designee under the Texas Medical Assistance Program.



Item 5 Reimbursement Methodology for the Pharmacy Dispensing Fee

I. General

The upper limit for payment for prescribed drugs, whether legend or non-legend items, will be based on the lower of cost as defined by the State Agency plus a dispensing fee as defined and determined by the State Agency or the usual and customary charge. Where a public agency makes bulk purchases of drugs, payment will be made in accordance with the governmental statutes and regulations governing such purchases in accordance with the agreement between such public agency and the State Agency. These provisions do not apply to payment for drugs in hospitals and other institutions where drugs are included in the reimbursement formula and vendor payment to the institution.

TDHS will advise HCFA in writing of the uniform reasonable dispensing fee which will be used to establish how the State is in compliance with the upper limit as specified in the regulations and as determined by the methodology described in this Plan. Such notice will specify the time period for which it is effective.

II. Reimbursement Methodology

The Texas Department of Health (department) reimburses contracted Medicaid pharmacy providers according to the dispensing fee formula defined in this section. The dispensing fee is determined by the following formula: Dispensing Fee = (((Estimated Drug Ingredient Cost + Estimated Dispensing Expense) divided by (1 - Inventory Management Factor)) - Estimated Drug Ingredient Cost) + Delivery Incentive.

A. Drug Ingredient Cost

The estimated drug ingredient costs are defined in Section II C (Estimated Acquisition Cost) and II D (Maximum Allowable Cost).

B. Dispensing Fee Determination

(1.) The estimated dispensing expense is $5.27 for state fiscal year 1997. This will be adjusted annually to account for general inflation.

(2.) The inflation adjustment will be made, on the first day of the State fiscal year. The projected rate of inflation for the State fiscal years subsequent to State fiscal year 1997 shall be based upon a forecast of the Implicit Price Deflator - Personal Consumption Expenditures, produced by a nationally recognized forecasting firm.

(3.) The inventory management factor is 2%.

STATE Texas
DATE REC'D 09-30-97
DATE APPV'D 06-11-98
DATE EFF 09-01-97
HCFA 179 97-15

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SUPERSEDES: TN • 96-04